



***RFA-AI-05-002***

***Units for HIV/AIDS Clinical Trials  
Networks***

**How to Structure the Budget**





## *GRANT WRITING WORKSHOP*

- Application Preparation using the Public Health Service (PHS) 398 Form, including information on changes in the newest form, revised 09/2004
- Review of Budget Categories, and
- Discuss selected grants policy and administrative issues



## *GRANT WRITING WORKSHOP*

- Application Preparation using the Public Health Service (PHS) 398 Form Revised 09/2004.





Form Approved Through 09/30/2007		OMB No. 0925-0001	
Department of Health and Human Services Public Health Services		LEAVE BLANK—FOR PHS USE ONLY	
Grant Application		Type	Activity
Do not exceed character length restrictions (indicated).		Review Group	Formerly
		Council/Board (Month, Year)	Date Received
1. TITLE OF PROJECT (Do not exceed 81 characters, including spaces and punctuation.) <b>AIDS/HIV Prevention Research</b>			
2. RESPONSE TO SPECIFIC REQUEST FOR APPLICATIONS OR PROGRAM ANNOUNCEMENT OR SOLICITATION <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES (If "Yes," state number and title) Number: <b>AH-00X</b> Title: <b></b>			
3. PRINCIPAL INVESTIGATOR/PROGRAM DIRECTOR		New Investigator <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
3a. NAME (Last, first, middle) <b>Grant, Apple B.</b>	3b. DEGREE(S) <b>MD PhD</b>	3c. eRA Commons User Name <b></b>	
3d. POSITION TITLE <b>Associate Professor</b>	3e. MAILING ADDRESS (Street, city, state, zip code) <b>University of Good Health Disease Prevention and Control 123 International Drive City, State, Zip Code</b>		
3f. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT <b>International Health</b>			
3g. MAJOR SUBDIVISION <b>Disease Prevention and Control</b>			
3h. TELEPHONE AND FAX (Area code, number and extension) TEL: <b>801-123-4567</b> FAX: <b>801-987-6543</b>		E-MAIL ADDRESS: <b>abc@XXXX.ORG</b>	
4. HUMAN SUBJECTS RESEARCH <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	4b. Human Subjects Assurance No. <b>FVWA 000000000</b>	5. VERTEBRATE ANIMALS <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	
4c. Clinical Trial <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	4d. NIH-defined Phase III Clinical Trial <input type="checkbox"/> No <input checked="" type="checkbox"/> Yes	5a. PHS/100C approval Date <b>00/00/05</b>	5b. Animal welfare assurance no. <b>A-0000-01</b>
4e. Research Exempt <input checked="" type="checkbox"/> No <input type="checkbox"/> Yes	If "Yes," Exemption No. <b></b>		
6. DATES OF PROPOSED PERIOD OF SUPPORT (month, day, year—MM/DD/YYYY) From <b>05/01/2006</b> Through <b>04/30/2011</b>		7. COSTS REQUESTED FOR INITIAL BUDGET PERIOD 7a. Direct Costs (\$) <b>\$200,000</b>	
		7b. Total Costs (\$) <b>\$300,000</b>	
		8a. Direct Costs (\$) <b>\$1,000,000</b>	
		8b. Total Costs (\$) <b>\$1,500,000</b>	
9. APPLICANT ORGANIZATION Name <b>University of Good Health</b> Address <b>School of Public Health 123 International Drive Room number City, State Zip Code Country (if outside the US)</b>		10. TYPE OF ORGANIZATION Public: <input type="checkbox"/> Federal <input type="checkbox"/> State <input type="checkbox"/> Local Private: <input checked="" type="checkbox"/> Private Nonprofit For-profit: <input type="checkbox"/> General <input type="checkbox"/> Small Business <input type="checkbox"/> Woman-owned <input type="checkbox"/> Socially and Economically Disadvantaged	
		11. ENTITY IDENTIFICATION NUMBER DUNS NO. <b></b> Cong. District <b></b>	
12. ADMINISTRATIVE OFFICIAL TO BE NOTIFIED IF AWARD IS MADE Name <b>Joe Accountant</b> Title <b>Chief, Financial Office, Research Administration</b> Address <b>123 International Drive Administration Building, Room XXX City, State, Zip Code</b> Tel: <b>to be completed</b> FAX: <b>to be completed</b> E-Mail: <b>to be completed</b>		12. OFFICIAL SIGNING FOR APPLICANT ORGANIZATION Name <b>Debra Dean</b> Title <b>Assistant Dean, Research Administration</b> Address <b>123 International Drive Administration Building, Room ZZZ City, State, Zip Code</b> Tel: <b>to be completed</b> FAX: <b>to be completed</b> E-Mail: <b>to be completed</b>	
14. PRINCIPAL INVESTIGATOR OR PROGRAM DIRECTOR ASSURANCE: I certify that the statements herein are true, complete and accurate to the best of my knowledge. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. I agree to accept responsibility for the scientific conduct of the project and to provide the required progress reports if a grant is awarded as a result of this application.		SIGNATURE OF PI/PO NAMED IN 3a. (In ink. "Per" signature not acceptable.) <b></b> DATE <b></b>	
15. APPLICANT ORGANIZATION CERTIFICATION AND ACCEPTANCE: I certify that the statements herein are true, complete and accurate to the best of my knowledge, and accept the obligation to comply with Public Health Services terms and conditions if a grant is awarded as a result of this application. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties.		SIGNATURE OF OFFICIAL NAMED IN 12. (In ink. "Per" signature not acceptable.) <b></b> DATE <b></b>	





- Actual Size
- FEDERAL BUREAU OF INVESTIGATION
- FD-302 (Rev. 10-6-95)
- Bureau of Health and Human Services
- Public Health Service
- Grant Application
- (Do not make alterations through which contents become falsified.)
- DATE RECEIVED FOR THIS USE ONLY
- |                         |               |        |
|-------------------------|---------------|--------|
| Name                    | Priority      | Number |
| And/or Group            | Priority      |        |
| Consolidated Month Year | Date Received |        |
1. TITLE OF PROJECT (Do not exceed 100 characters, including spaces and punctuation)
2. RESPONSE TO REQUEST FOR PROPOSAL APPLICATIONS ON PROGRAM REDESIGNING OR REDIRECTION ☐ NO ☐ YES  
Receiving: Title
3. PRINCIPAL INVESTIGATOR/PROGRAM DIRECTOR
- Is an Investigator ☐ No ☐ Yes
4. NAME (Last, first, middle)
- Is a Health Services Executive
5. PROJECT TITLE
6. MAILING ADDRESS (Include zip code and city)
7. DEPARTMENT (OFFICE, LABORATORY, OR DIVISION)
8. REAKS SUBDIVISION
- 9a. TELEPHONE AND FAX (Give area code, number and extension)
- E-MAIL ADDRESS:
- Title:
- 9b. TELEPHONE EXTENSION (Include area code)
6. WESTERLY ADDRESS ☐ No ☐ Yes
10. TELEPHONE EXTENSION
10. TYPE OF PROJECT ☐ No ☐ Yes
11. TELEPHONE EXTENSION
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89. TELEPHONE EXTENSION





Form Approved Through 09/30/2007

OMB No. 0925-0001

Department of Health and Human Services  
Public Health Services**Grant Application***Do not exceed character length restrictions indicated.***LEAVE BLANK—FOR PHS USE ONLY.**

Type	Activity	Number
Review Group	Formerly	
Council/Board (Month, Year)	Date Received	

1. TITLE OF PROJECT (*Do not exceed 81 characters, including spaces and punctuation.*)

UNIVERSITY OF BETHESDA CLINICAL TRIAL UNIT

2. RESPONSE TO SPECIFIC REQUEST FOR APPLICATIONS OR PROGRAM ANNOUNCEMENT OR SOLICITATION ☐ NO ☒ YES  
(*If "Yes," state number and title*)

Number: RFA-AI-05-002

Title: Units for HIV/AIDS Clinical Trials Networks

**3. PRINCIPAL INVESTIGATOR/PROGRAM DIRECTOR**New Investigator ☐ No ☐ Yes

3a. NAME (Last, first, middle)

3b. DEGREE(S)

3h. eRA Commons User Name

3c. POSITION TITLE

3d. MAILING ADDRESS (*Street, city, state, zip code*)

3e. DEPARTMENT, SERVICE, LABORATORY, OR EQUIVALENT

3f. MAJOR SUBDIVISION

3g. TELEPHONE AND FAX (*Area code, number and extension*)

TEL:

FAX:

E-MAIL ADDRESS:

4. HUMAN SUBJECTS  
RESEARCH☐ No ☐ Yes

4b. Human Subjects Assurance No.

4c. Clinical Trial

☐ No ☐ Yes

4d. NIH-defined Phase III

Clinical Trial

☐ No ☐ Yes5. VERTEBRATE ANIMALS ☐ No ☐ Yes5a. If "Yes," IACUC approval  
Date

5b. Animal welfare assurance no.

4a. Research Exempt

☐ No ☐ Yes

If "Yes," Exemption No.

6. DATES OF PROPOSED PERIOD OF  
SUPPORT (*month day year—MM/DD/YYYY*)7. COSTS REQUESTED FOR INITIAL  
BUDGET PERIOD8. COSTS REQUESTED FOR PROPOSED  
PERIOD OF SUPPORT



<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes					
6. DATES OF PROPOSED PERIOD OF SUPPORT (month, day, year—MM/DD/YY)		7. COSTS REQUESTED FOR INITIAL BUDGET PERIOD		8. COSTS REQUESTED FOR PROPOSED PERIOD OF SUPPORT	
From	Through	7a. Direct Costs (\$)	7b. Total Costs (\$)	8a. Direct Costs (\$)	8b. Total Costs (\$)
05/01/2006	04/30/2011	\$200,000	\$300,000	\$1,000,000	\$1,500,000
9. APPLICANT ORGANIZATION			10. TYPE OF ORGANIZATION		
Name	University of Good Health		Public: → <input type="checkbox"/> Federal <input type="checkbox"/> State <input type="checkbox"/> Local		
Address	School of Public Health 123 International Drive Room number City, State Zip Code Country (if outside the US)		Private: → <input checked="" type="checkbox"/> Private Nonprofit		
			For-profit: → <input type="checkbox"/> General <input type="checkbox"/> Small Business		
			<input type="checkbox"/> Woman-owned <input type="checkbox"/> Socially and Economically Disadvantaged		
			11. ENTITY IDENTIFICATION NUMBER		
			DUNS NO. Cong. District		
12. ADMINISTRATIVE OFFICIAL TO BE NOTIFIED IF AWARD IS MADE			13. OFFICIAL SIGNING FOR APPLICANT ORGANIZATION		
Name	Joe Accountant		Name	Debra Dean	
Title	Chief, Financial Office, Research Administration		Title	Assistant Dean, Research Administration	
Address	123 International Drive Administration Building, Room XXX City, State, Zip Code		Address	123 International Drive Administration Building, Room ZZZ City, State, Zip Code	
Tel:	to be completed	FAX:	to be completed	Tel:	to be completed
E-Mail:	to be completed		E-Mail:	to be completed	
14. PRINCIPAL INVESTIGATOR/PROGRAM DIRECTOR ASSURANCE: I certify that the statements herein are true, complete and accurate to the best of my knowledge. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. I agree to accept responsibility for the scientific conduct of the project and to provide the required progress reports if a grant is awarded as a result of this application.			SIGNATURE OF PI/PPD NAMED IN 3a. (In ink. "Per" signature not acceptable.)		DATE
15. APPLICANT ORGANIZATION CERTIFICATION AND ACCEPTANCE: I certify that the statements herein are true, complete and accurate to the best of my knowledge, and accept the obligation to comply with Public Health Services terms and conditions if a grant is awarded as a result of this application. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties.			SIGNATURE OF OFFICIAL NAMED IN 13. (In ink. "Per" signature not acceptable.)		DATE



# *New Application 398 changes*

## ❖ Form Page 2 & Form Page 2 Continued

- ❖ 5 distinct sections—Description, Performance Sites, Key Personnel, Other Significant Contributors, and Stem Cells.
- ❖ Description/Abstract : **Instructions have been added requiring the PI to succinctly (2-3 sentences) describe the relevance of the proposed research to public health.** Plain language is suggested.

Principal Investigator/Program Director (Last, First, Middle):

DESCRIPTION: See instructions. State the application's broad, long-term objectives and specific aims, making reference to the health relatedness of the project (i.e., relevance to the mission of the agency). Describe concisely the research design and methods for achieving these goals. Describe the rationale and techniques you will use to pursue these goals.

In addition, in two or three sentences, describe in plain, lay language the relevance of this research to public health. If the application is funded, this description, as it, will become public information. Therefore, do not include proprietary/confidential information. DO NOT EXCEED THE SPACE PROVIDED.

PERFORMANCE SITE(S) (organization, city, state)

PHS 398 (Rev. 09/04)

Page 2

Form Page 2





# New Application 398 changes

- **Form Page 2 & Form Page 2 Continued**
- Key Personnel Section : A field has been added for the eRA Commons User Name.

- Other Significant Contributors: This is a new field that allows identification of individuals who will contribute to the scientific development or execution of the project but are *not* committing specified measurable effort.

- Biographical sketches will be required for these individuals;
- Other Support information will not be required.

- Human Embryonic Stem Cells: requested as a separate form field.

Principal Investigator/Program Director (Last, First, Middle)  
KEY PERSONNEL: See Instructions. See instructions page(s) needed to provide the required information to the Principal Investigator.  
Enter with Principal Investigator. List all other key personnel in alphabetical order, last name first.  
Name eRA Commons User Name Organization Federal Project

OTHER SIGNIFICANT CONTRIBUTORS  
Name Organization Federal Project

Human Embryonic Stem Cells ☐ Yes ☐ No  
If the program/project involves human embryonic stem cells, list below the principal investigator of the specific cell study (provide following link: <http://www.fda.gov/oc/ohrt/ohrtfaq.htm>). See instructions page(s) needed.  
If a specific investigator information is not available, list the investigator that you hope to contact with the cell study.  
Cell Study

Director/Program Director/Principal Investigator ☐ Yes ☐ No  
Page 2 Page 2 Continued



# New 398 Application

## PHS Form Page 3

Principal Investigator/Program Director (Last, First, Middle): \_\_\_\_\_  
The name of the principal investigator/program director must be provided at the top of each printed page and each continuation page.

**RESEARCH GRANT  
TABLE OF CONTENTS**

	Page Number
Face Page.....	1
Description, Performance Sites, Key Personnel, Other Significant Contributors, and Human Embryonic Stem Cells.....	2
Table of Contents.....	3
Detailed Budget for Initial Budget Period (or Modular Budget).....	4
Budget for Entire Proposed Period of Support (not applicable with Modular Budget).....	5
Budgets Pertaining to Consortium/Contractual Arrangements (not applicable with Modular Budget).....	6
Biographical Sketch – Principal Investigator/Program Director (Not to exceed four pages).....	7
Other Biographical Sketches (Not to exceed four pages for each – See Instructions).....	8
Resources.....	9
Research Plan.....	10
Introduction to Revised Application (Not to exceed 2 pages).....	11
Introduction to Supplemental Application (Not to exceed one page).....	12
A. Specific Aims.....	13
B. Background and Significance.....	14
C. Preliminary Studies/Progress Report/.....	15
Phase I Progress Report (SBIR/STTR Phase II ONLY).....	16
D. Research Design and Methods.....	17
E. Human Subjects.....	18
Protection of Human Subjects (Required if Item 4 on the Face Page is marked "Yes").....	19
Inclusion of Women and Minorities (Required if Item 4 on the Face Page is marked "Yes" and is Clinical Research).....	20
Targeted/Planned Enrollment Table (for new and continuing clinical research studies).....	21
Inclusion of Children (Required if Item 4 on the Face Page is marked "Yes").....	22
Data and Safety Monitoring Plan (Required if Item 4 on the Face Page is marked "Yes" and a Phase I, II, or III clinical trial is proposed).....	23
F. Vertebrate Animals.....	24
G. Literature Cited.....	25
H. Consortium/Contractual Arrangements.....	26
I. Resource Sharing.....	27
J. Letters of Support (e.g., Consultants).....	28
Commercialization Plan (SBIR/STTR Phase II and Fast-Track ONLY).....	29
Checklist.....	30
Appendix (The dotted line. No page numbering necessary for Appendix).....	31
Appendices NOT PERMITTED for Phase I SBIR/STTR unless specifically solicited.....	32
Number of publications and manuscripts accepted for publication (not to exceed 10).....	33
Other Items (if any).....	34

PHS 398 (Rev. 09/04) Page Form Page 3

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Please Note: pages must be paginated sequentially





# *Changes in New 398 Application*

- ❖ **Biographical Sketch Format Page :** A field has been added for the eRA Commons User Name.
- ❖ **Personal Data Page:** Applicants are now requested to provide only the last four digits of the Social Security Number. Still voluntary.
- ❖ **Checklist Form Page:**
  - ❑ Foreign Application: Two distinct options are now provided 1) Grants at Foreign Institutions or 2) Domestic Grants with Significant Foreign Involvement. This data area also includes a text entry section to list countries involved.



Please adjust size to meet formatting modifications. Make sure "Metric overlaid points as visible" is NOT checked in Plot window.

FAC-000 (Rev. 0000) Page \_\_\_\_ From Page \_\_\_\_



# New 398 Application changes

## Budget pages 4 and 5

● Budget pages have been modified:

- Separate the Direct and F & A for Consortium
- New Subtotal for Direct Costs

TRAVEL		
PATIENT CARE COSTS	INPATIENT	
	OUTPATIENT	
ALTERATIONS AND RENOVATIONS (Resize by category)		
OTHER EXPENSES (Resize by category)		
CONSORTIUM/CONTRACTUAL COSTS		DIRECT COSTS
SUBTOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD (Rem 7a, Face Page)		\$
CONSORTIUM/CONTRACTUAL COSTS		FACILITIES AND ADMINISTRATIVE COSTS
TOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD		\$
SBIR/STTR Only: FEE REQUESTED		

PHS 398 (Rev. 09/04) Page Form Page 4

CONSORTIUM/CONTRACTUAL COSTS	OUTPATIENT								
ALTERATIONS AND RENOVATIONS									
OTHER EXPENSES									
CONSORTIUM/CONTRACTUAL COSTS	DIRECT								
CONSORTIUM/CONTRACTUAL COSTS	F&A								
SUBTOTAL DIRECT COSTS (Sum = Item 8a, Face Page)									
TOTAL DIRECT COSTS									
TOTAL DIRECT COSTS FOR ENTIRE PROPOSED PROJECT PERIOD									
SBIR/STTR Only: Fee Requested									
SBIR/STTR Only: Total Fee Requested for Entire Proposed Project Period (Enter Total Fee Requested for Entire Proposed Project Period, above and Total Fee Requested from Checklist Form Page, and enter these as "Total Fee Requested for Proposed Project of Support on Face Page, Item 8c.)									
REMARKS: Follow the budget justification instructions exactly. Use continuation pages as needed.									



# GRANT WRITING WORKSHOP

## *Review of Budget Cost Categories*

- Highlight costs specific to foreign applicants, and
- Discussion of selected grants policy and administrative issues



## *Costs for All Foreign Grantees*

### ✚ Allowable

- ✚ Most of the same costs allowable to domestic grantees including protocol and participant costs
- ✚ “F & A”, Facilities and Administrative costs up to 8% less equipment.

### ✚ Unallowable

- ✚ Customs and import duties, (consular fees, custom surtax)
- ✚ Alteration and renovation
- ✚ Hospital research patient care rates



# *Allowable Foreign Unit/Site Costs*

*GNI > USD \$5,000 per capita*

- May request allowable expenses:
- Protocol clinical research costs (recruitment, screening, etc.);
- Administrative (P.I., data management, coordinators, essential equipment, supplies, travel & communication costs)
- F & A up to 8% less equipment





# *Allowable Foreign Unit/Site Costs*

*GNI < USD \$5,000 per capita*

- ✚ May request all costs allowable for USD > \$5,000 per cap.
- ✚ PLUS:
- ✚ Additional administrative and facilities expenses such as security costs, power maintenance (generators), transportation (vehicle), necessary to meet project goals



# Budget Categories

## PHS 398 Form Page 4

Principal Investigator/Program Director (Last, First, Middle): **Grant, Apple B., MD PhD**

DETAILED BUDGET FOR INITIAL BUDGET PERIOD DIRECT COSTS ONLY					FROM <b>05/01/2005</b>	THROUGH <b>04/30/2007</b>	
PERSONNEL (Allocate organization only)		TYPE APPT. (months)	% EFFORT ON PROJ.	INST. BASE SALARY	DOLLAR AMOUNT REQUESTED (omit cents)		
NAME	ROLE ON PROJECT				SALARY REQUESTED	FRINGE BENEFITS	TOTAL
Apple Grant	Principal Investigator	12	50.0				
Carmen Clinician	Research Clinician	12	100.0				
Steve Coordinator	Site Coordinator	12	100.0				
Ivy Nurse	Clinical Nurse	12	100.0				
Larry Labcoat	Lab/Nurse Assistant	12	100.0				
Cathy Communicator	Interviewer	12	100.0				
TBN	Med.Tech	12	100.0				
SUBTOTALS							
CONSULTANT COSTS							
Consultant A: 300 hours @ \$50 per hour \$15,000; Consultant B: 40 hours @ 100 per hour							
EQUIPMENT (Itemize)							
Freezer \$4,000; desktop computers 3 @ \$1,000 ea.; Centrifuge \$1,200; ELISA plate reader							
SUPPLIES (Itemize by category)							
Chemicals and solvents \$2,500; Laboratory Supplies \$3,500; Disposables \$3,000; Lymphocyte proliferation assays \$7,000; Elispot reagents \$1,500							
TRAVEL							
Local travel - patient recruitment; visits to sites; participant travel;							
PATIENT CARE COSTS							
INPATIENT							
OUTPATIENT							
ALTERATIONS AND RENOVATIONS (Itemize by category)							
N/A							
OTHER EXPENSES (Itemize by category)							
Equipment service contracts, \$3,000; Shipping costs \$2,000; Computer and printer supplies \$1,000; Telecommunications \$3,000;							
CONSORTIUM/CONTRACTUAL COSTS					DIRECT COSTS		
SUBTOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD (Item 7a, Face Page)					\$		
CONSORTIUM/CONTRACTUAL COSTS					FACILITIES AND ADMINISTRATIVE COSTS		
TOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD					\$		
SBIR/STTR Only: FEE REQUESTED							

PHS 398 (Rev. 02/04) Page **4** Form I/ Page 4

**Divides budget into specific cost categories.**

**Include a breakdown of items within each category.**



# Budget Categories Form Page 5

Principal Investigator/Program Director (Last, First, Initial) Grant, Apple B. MD, PhD

**BUDGET FOR ENTIRE PROPOSED PROJECT PERIOD  
DIRECT COSTS ONLY**

BUDGET CATEGORY TOTALS	INITIAL BUDGET PERIOD (From Form Page 4)		ADDITIONAL YEARS OF SUPPORT REQUESTED			
	200	201	202	203	204	205
PERSONNEL: Salary and fringe benefits, dependent upon an R01						
CONSULTANT COSTS						
EQUIPMENT						
SUPPLIES						
TRAVEL						
OUTPATIENT CARE COSTS						
INPATIENT CARE COSTS						
ALTERNATIVES AND NEGOTIATIONS						
OTHER EXPENSES						
CONTRACTUAL COSTS						
SUBTOTAL DIRECT COSTS (Sum of Item 2a-2j)						
CONTRACTUAL COSTS						
TOTAL DIRECT COSTS						
TOTAL DIRECT COSTS FOR ENTIRE PROPOSED PROJECT PERIOD						
EBR/ATTR Only Fee Requested						
EBR/ATTR Only: Total Fee Requested for Entire Proposed Project Period						
<small>(List Fee amount in Total Direct Costs to entire proposed project period above and Total F&amp;A indirect cost amount below. Do not enter these as Direct Costs Requested for Proposed Period of Support on Form Page 5b.)</small> <small>CONFIRMATION: Enter the budget justification on supporting document. (See instructions on Page 1a.)</small> <small>Provide detailed justification per category. Provide sufficient information to support all requested personnel positions, effort level, role on project, etc. All other costs must also be well justified. Do not expect reviewers to know why certain budget items are requested.</small>						

PHS 205 (Rev. 10/04) Page 5 Form Page 5

- Provides a breakdown of future year costs by category and per year.
- Also includes a section for narrative justification to support your requested budget. Provide justification by categories and items.
- Additional pages will be necessary for thorough justification



# *Budget Categories*

## *Categories for review and discussion*

- Personnel
- Consultant
- Travel
- Hospital Research Patient Care
- Other Expenses
- Consortia and subcontracts



# Budget Categories

## Personnel

Principal Investigator/Program Director (Last, First, Middle): <b>Grant, Apple B., MD PhD</b>							
<b>DETAILED BUDGET FOR INITIAL BUDGET PERIOD DIRECT COSTS ONLY</b>					FROM <b>05/01/2006</b>	THROUGH <b>04/30/2007</b>	
PERSONNEL (Applicant organization only)			%		DOLLAR AMOUNT REQUESTED (omit cents)		
NAME	ROLE ON PROJECT	TYPE APPT. (months)	EFFORT ON PROJ.	INST. BASE SALARY	SALARY REQUESTED	FRINGE BENEFITS	TOTAL
Apple Grant	Principal Investigator	12	50.0				
Carmen Clinician	Research Clinician	12	100.0				
Steve Coordinator	Site Coordinator	12	100.0				
Ivy Needle	Clinical Nurse	12	100.0				
Larry Labcoat	Lab/Nurse Assistant	12	100.0				
Cathy Communicator	Interviewer	12	100.0				
TBN	Med.Tech	12	100.0				
<b>SUBTOTALS</b>							
CONSULTANT COSTS							
Consultant A 300 hours @ \$50 per hour \$15,000; Consultant B 40 hours @ 100 per hour							

The people listed here must be employees of the applicant organization( item # 9 on 398 face page)



# Budget Categories

## Personnel Chart Clarification

Principal Investigator/Program Director (Last, First, Middle):					Grant, Apple B., MD PhD		
<b>DETAILED BUDGET FOR INITIAL BUDGET PERIOD DIRECT COSTS ONLY</b>					FROM 05/01/2006	THROUGH 04/30/2007	
PERSONNEL (Applicant organization only)			%		DOLLAR AMOUNT REQUESTED (omit cents)		
NAME	ROLE ON PROJECT	TYPE APPT. (months)	EFFORT ON PROJ.	INST. BASE SALARY	SALARY REQUESTED	FRINGE BENEFITS	TOTAL
Apple Grant	Principal Investigator	12	50.0				
Carmen Clinician	Research Clinician	12	100.0				
Steve Coordinator	Site Coordinator	12	100.0				
Ivy Needle	Clinical Nurse	12	100.0				
Larry Labcoat	Lab/Nurse Assistant	12	100.0				
Cathy Communicator	Interviewer	12	100.0				
TBN	Med Tech	12	100.0				
<b>SUBTOTALS</b>							
CONSULTANT COSTS							
Consultant A 300 hours @ \$50 per hour \$15,000; Consultant B 40 hours @ 100 per hour							

Months per year employed by applicant organization;  
 Based on US standard of 40 hours per week-example:50% effort = 20 hours per week.  
 Amount applicant organization pays named employee annually.





# *Budget Categories*

## *Personnel Fringe Benefits*


- ✚ In addition to salary some organizations provide Fringe
- ✚ Benefits as part of overall compensation to their
- ✚ employees.
- ✚ Fringe Benefits may include such employee costs as Insurance; Sabbatical Leave; Retirement Savings; and/or Dues and Fees for membership in professional organizations.
- ✚ Fringe Benefits are an allowable charge, if they are included in a formally established and consistently applied practice of the applicant organization. Requests for Fringe Benefits must be in proportion to the effort devoted to the project



# Budget Categories

## Consultant Costs

TEN	Med.Tech	12	100.0				
SUBTOTAL:							
CONSULTANT COSTS							
Consultant A: 300 hours @ \$50 per hour \$15,000; Consultant B: 40 hours @ 100 per hour							
EQUIPMENT (Hemol)							
Equipment \$1,000; Consultant A: \$1,000; Consultant B: \$1,000; Equipment \$1,000							

-  A professional hired to provide advice, guidance or service for a fee. A consultant is NOT an employee of the applicant organization.





# Budget Categories

## Equipment

<b>EQUIPMENT</b> (itemize)	
Freezer \$4,000; desktop computers 3 @ \$1,000 ea.; Centrifuge \$1,200; ELISA plate reader	
<b>SUPPLIES</b> (itemize by category)	
Chemicals and solvents \$2,500; Laboratory Supplies \$3,500; Disposables \$3,000; Lymphocyte proliferation assays \$7,000; Elispot reagents \$1,500	

- ❖ Equipment: Generally defined as an instrument, machine, tool or that can be used for more than one year.
- ❖ Request equipment necessary to do the proposed work, itemize cost per item.



# Budget Categories

## Supplies

<b>EQUIPMENT</b> (Itemize)	
Freezer \$4,000; desktop computers 3 @ \$1,000 ea.; Centrifuge \$1,200; ELISA plate reader	
<b>SUPPLIES</b> (Itemize by category)	
Chemicals and solvents \$2,500; Laboratory Supplies \$3,500; Disposables \$3,000; Lymphocyte proliferation assays \$7,000; Elispot reagents \$1,500	

- Small items and other materials used for project. Examples include chemicals, glassware, etc.
- Itemize requests and include calculation: ELISA kits  
# of kits X cost per kit = \$ZZ



# Budget Categories

## Travel

TRAVEL		
Local travel - patient recruitment; visits to sites; participant travel;		
PATIENT CARE COSTS	INPATIENT	
	OUTPATIENT	
ALTERATIONS AND RENOVATIONS (Number by category)		

- Request travel necessary for project. Such as travel to visits sites, participant recruitment.
- Grantees are required to use US Flag carriers or code-share carriers to the extent possible. One exception is travel within a foreign country.



# Budget Categories

## Research Patient Care Costs

TOTAL		
Local travel - patient recruitment; visits to sites; participant travel;		
PATIENT CARE COSTS	INPATIENT	
	OUTPATIENT	
ALTERATIONS AND RENOVATIONS (Itemize by category)		
N/A		
OTHER EXPENSES (Itemize by category)		
Construction contracts: \$0.000; Cleaning costs: \$0.000; Computer and printer supplies:		

- Definition: Costs of routine and ancillary services provided by hospitals to research participants. Rates are developed for US hospitals and are consistent with US Medicare reimbursement.



# Budget Categories

## Research Patient Care Costs

HOSPITAL		
Local travel - patient recruitment; visits to sites; participant travel;		
PATIENT CARE COSTS	INPATIENT	
	OUTPATIENT	
ALTERATIONS AND RENOVATIONS (Itemize by category)		
N/A		
OTHER EXPENSES (Itemize by category)		
Equipment purchase contracts: \$0.000; Computer costs: \$0.000; Computer and printer supplies:		

- Hospital Research Patient Care Rates are for domestic grantees only. All Grantees may request necessary protocol and patient related costs in other budget categories on the PHS 398 form pages.



# *Budget Categories*

## *Recap Research Patient Care*

- **Definition:** Cost of routine and ancillary services provided by hospitals to research participants.
- **Rates are developed** through DCA for U.S. Hospitals only. Rates are consistent with Medicare reimbursement and include F&A.
- **These DO NOT apply to foreign grantees**



# *Budget Categories*

## *Examples of Allowable Research Participant /Patient Costs*

- ✚ research protocol costs
- ✚ recruitment costs
- ✚ participant incentives and transportation
- ✚ clinical screening tests.



# Budget Categories

## Other Expenses

OTHER EXPENSES (Itemize by category) Equipment service contracts, \$3,000; Shipping costs \$2,000 Computer and printer supplies \$1,000; Telecommunications \$3,000;		
CONSORTIUM CONTRACTUAL COSTS	DIRECT COSTS	
SUBTOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD (Item 7a, Face Page)	\$	
CONSORTIUM CONTRACTUAL COSTS	FACILITIES AND ADMINISTRATIVE COSTS	
TOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD	\$	

- Other items that are necessary for the project. Examples include communication costs, service contracts, lab costs, participant incentives, etc., etc. Itemize costs.





# Budget Consortium

CONSORTIUM/CONTRACTUAL COSTS	DIRECT COSTS	22,860
SUBTOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD (Item 7a, Face Page)	\$	222,860
CONSORTIUM/CONTRACTUAL COSTS	FACILITIES AND ADMINISTRATIVE COSTS	11,430
TOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD	\$	234,290
SBIR/STTR Only: FEE REQUESTED		

NAME: F Lee Bailey

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Investigator	12	10.0	70,000	7,000	750	7,750	
Tina Turner	Research Spec	12	50.0	24,000	12,000	610	12,610
SUBTOTALS				19,000	1,360	20,360	

CONSULTANT COSTS

EQUIPMENT (Itemize)

SUPPLIES (Itemize by category)  
General Laboratory Supplies

TRAVEL

PATIENT CARE COSTS

ALTERATIONS AND RENOVATIONS (Itemize by category)

OTHER EXPENSES (Itemize by category)  
Shipping and courier services

500

CONSORTIUM/CONTRACTUAL COSTS	DIRECT COSTS	22,860
SUBTOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD (Item 7a, Face Page)	\$	
CONSORTIUM/CONTRACTUAL COSTS	FACILITIES AND ADMINISTRATIVE COSTS	11,430
TOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD	\$	34,290
SBIR/STTR Only: FEE REQUESTED		

Page

Form Page 4

Applications with consortiums will always have at least two Page 4 and 5

1. For the application which includes the totals for each consortium budget
2. For each consortium





# CONSORTIUM

Detail of Form Page 4 con't

CONSORTIUM/CONTRACTUAL COSTS	DIRECT COSTS	613,125
<b>SUBTOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD</b> (Item 7a, Face Page)		<b>\$ 1,107,500</b>
CONSORTIUM/CONTRACTUAL COSTS	FACILITIES AND ADMINISTRATIVE COSTS	212,193
<b>TOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD</b>		<b>\$ 1,319,693</b>
<b>SBIR/STTR Only: FEE REQUESTED</b>		

OTHER EXPENSES (Itemize by category)  
Patient Reimbursement: 4,000  
Laboratory Costs: 10,000

CONSORTIUM/CONTRACTUAL COSTS	DIRECT COSTS	14,000
<b>SUBTOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD</b> (Item 7a, Face Page)		<b>\$ 270,625</b>
CONSORTIUM/CONTRACTUAL COSTS	FACILITIES AND ADMINISTRATIVE COSTS	115,312
<b>TOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD</b>		<b>\$ 385,937</b>
<b>SBIR/STTR Only: FEE REQUESTED</b>		

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Form Page 4

Harborview Core

OTHER EXPENSES (Itemize by category)  
Shipping and Courier: 2,000  
Laboratory Costs: 30,000

CONSORTIUM/CONTRACTUAL COSTS	DIRECT COSTS	32,000
<b>SUBTOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD</b> (Item 7a, Face Page)		<b>\$ 176,500</b>
CONSORTIUM/CONTRACTUAL COSTS	FACILITIES AND ADMINISTRATIVE COSTS	13,880
<b>TOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD</b>		<b>\$ 190,380</b>
<b>SBIR/STTR Only: FEE REQUESTED</b>		

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Page

Form Page 4

South Asia Clinical Research Site

Patient Reimbursement: 4,000  
Laboratory Costs: 19,125

CONSORTIUM/CONTRACTUAL COSTS	DIRECT COSTS	14,000
<b>SUBTOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD</b> (Item 7a, Face Page)		<b>\$ 166,000</b>
CONSORTIUM/CONTRACTUAL COSTS	FACILITIES AND ADMINISTRATIVE COSTS	83,000
<b>TOTAL DIRECT COSTS FOR INITIAL BUDGET PERIOD</b>		<b>\$ 249,000</b>
<b>SBIR/STTR Only: FEE REQUESTED</b>		

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Form Page 4

Harborview Transition Costs

- Enter the totals for each consortium budget on the budget page of the applicant organization
- [Include Form Pages 4&5 for each consortium partner/site]

Application Meeting

March/April 2005



# *Budget Categories*

## *Consortium Definition*

- ❖ **A Consortium is a collaboration between the Applicant Organization and another Organization that contributes to the research project.**
- ❖ **A separate budget using PHS form pages 4 & 5 are required for the Consortium Organization**

### **ALLOWABLE COSTS** in consortiums:

**Direct Costs are the same types of costs as the host organization**

**Indirect Costs or Facilities and Administrative Cost.**

**For U.S. Institutions: use their negotiated rate; Non-US Institutions are allowed up to 8% applied to direct costs less equipment.**



# *Budget Categories*

## *Consortium Agreements*

- A written agreement between the applicant and consortium organizations, must be negotiated in accordance with NIH Grants Policy requirements.
- These agreements must be directly between the applicant organization and each consortium partner organization



# *Budget Categories*

## *Consortium Agreements, con't.*

- Note: a consortium partner's budget may not include a subcontract. This is called a "third tier" relationship.
- Third tier relationships are not allowed, however purchased service contracts are.
- Actual consortium vs. purchased service or service contract



# *Grant Writing Workshop Questions?*

